SERFF Tracking Number:	*WAKE-126945784*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*47525*
Company Tracking Number:	*KEGLOAAPPAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Life Application*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOAAPPAR*		

Filing at a Glance

Company: Life Insurance Company of Alabama

Product Name: Life Application	SERFF Tr Num: WAKE-126945784	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 47525
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num: KEGLOAAPPAR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Toni Hess, Katlyn Gorman, Austin Taylor, Michelle Miller, Ben Cohen	Disposition Date: 12/15/2010
	Date Submitted: 12/13/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Life Insurance Company of Alabama	Status of Filing in Domicile: Authorized
Project Number: KEGLOAAPPAR	Date Approved in Domicile: 12/13/2010
Requested Filing Mode: Review & Approval	Domicile Status Comments: This filing was approved by the home domicile state of Alabama on December 13, 2010.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 12/15/2010	Explanation for Other Group Market Type:
	State Status Changed: 12/15/2010
Deemer Date:	Created By: Katlyn Gorman
Submitted By: Katlyn Gorman	Corresponding Filing Tracking Number:

Filing Description:

Please see cover letter under supporting documentation tab for description of filing.

SERFF Tracking Number:	*WAKE-126945784*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*47525*
Company Tracking Number:	*KEGLOAAPPAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Life Application*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOAAPPAR*		

Company and Contact

Filing Contact Information

Katlyn Gorman, Administrative Assistant
34125 US Highway 19 North
Suite 310
Palm Harbor, FL 34684

katlyn.gorman@wakelyactuarial.com
888-590-5504 [Phone] 2100 [Ext]
727-373-4559 [FAX]

Filing Company Information

(This filing was made by a third party - WAS01)

Life Insurance Company of Alabama
302 Broad Street
Gadsden, AL 35901
(256) 543-2022 ext. [Phone]

CoCode: 65412
Group Code: -99
Group Name:
FEIN Number: 63-0321291

State of Domicile: Alabama
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	$50.00 per form X 1
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Life Insurance Company of Alabama	$50.00	12/13/2010	42868000

SERFF Tracking Number:	*WAKE-126945784*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*47525*
Company Tracking Number:	*KEGLOAAPPAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Life Application*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOAAPPAR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/15/2010	12/15/2010

SERFF Tracking Number:	*WAKE-126945784*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*47525*
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TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Life Application*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOAAPPAR*		

Disposition

Disposition Date: 12/15/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126945784*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*47525*
Company Tracking Number:	*KEGLOAAPPAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Life Application*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOAAPPAR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Authorization Letter		Yes
Supporting Document	Cover Letter		Yes
Form	Life Application		Yes

SERFF Tracking Number:	*WAKE-126945784*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*47525*
Company Tracking Number:	*KEGLOAAPPAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Life Application*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOAAPPAR*		

Form Schedule

Lead Form Number: MP LIFE 1010

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	MP LIFE 1010	Application/ Enrollment Form	Life Application	Revised	Replaced Form #: MP LIFE 7-10 Previous Filing #:	45.800	MP LIFE 1010.pdf

APPLICATION FOR LIFE INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.

Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

Proposed Insured

NAME (Last, Suffix, First, M.I.)_____

BIRTHDATE ___/___/_____ STATE OF BIRTH ____ SSN# ___-___-_____

HEIGHT ___' ___" WEIGHT ____ MALE ☐ FEMALE ☐ _____ ____ ISSUE STATE
Driver License #

ADDRESS_____

CITY_____ STATE ____ ZIP _____

EMAIL _____ PHONE ___-___-_____

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ___/___/_____

OCCUPATION_____
Describe and give exact duties

1. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **1a. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE ☐ E-Z Underwriting (Subject to Question 10 and Company Participation requirements)	$ ___,___	$ ___,___.___
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$ ___,___	$ ___,___.___
☐ ACCIDENTAL DEATH BENEFIT	$ ___,___	$ ___,___.___
☐ CHILDRENS TERM ____ UNITS 15 units maximum per family		$ ___,___.___
☐ WAIVER OF PREMIUM		$ ___,___.___
☐ AUTOMATIC PREMIUM LOAN Yes ☐ No ☐ Whole Life Only	TOTAL MODE PREMIUM	$ ___,___.___

Ownership

2. OWNER if other than PROPOSED INSURED

Name _____ *Relationship to Insured* _____

Street _____ Owner's SSN# or TAX ID# ___-___-_____

City _____ *State*____ *ZIP*_____

Proposed Insured becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

3. NAME	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

APPLICATION FOR LIFE INSURANCE - PART 2

Spouse

NAME (Last, Suffix, First, M.I.)_____

BIRTHDATE ☐☐/☐☐/☐☐☐☐ STATE OF BIRTH ☐☐ SSN# ☐☐☐-☐☐-☐☐☐☐

HEIGHT ☐'☐☐" WEIGHT ☐☐☐ MALE ☐ FEMALE ☐ _____ ☐☐ ISSUE STATE
Driver License #

ADDRESS_____
☐ Same address as Proposed Insured

CITY_____ STATE ☐☐ ZIP ☐☐☐☐☐

EMAIL _____ PHONE ☐☐☐-☐☐☐-☐☐☐☐

SPOUSE'S EMPLOYER _____ EMPLOYMENT DATE ☐☐/☐☐/☐☐☐☐

OCCUPATION_____
Describe and give exact duties

4. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **4a. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ ACCIDENTAL DEATH BENEFIT	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ CHILDRENS TERM ☐☐ UNITS 15 units maximum per family		$ ☐,☐☐☐.☐☐
☐ WAIVER OF PREMIUM		$ ☐,☐☐☐.☐☐
☐ AUTOMATIC PREMIUM LOAN Whole Life Only Yes ☐ No ☐	TOTAL MODE PREMIUM	$ ☐,☐☐☐.☐☐

Ownership

5. OWNER if other than SPOUSE

Name _____ *Relationship to Insured* _____

Street _____ Owner's SSN# or TAX ID# ☐☐☐-☐☐-☐☐☐☐

City _____ *State*____ *ZIP*_____

Spouse becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

6. NAME	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

Payment Info. Insured

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Proposed Insured's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Payment Info. Spouse

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7a. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Spouse's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Existing Insurance

8. EXISTING or APPLIED FOR INSURANCE

Does any Proposed Insured have any existing life insurance or annuity contracts in force or applications pending? Yes ☐ No ☐

If YES, complete and submit attached replacement forms with this application and list all in force and pending life insurance coverage below.

Insured's Name	Company	Owner	Replacement	Life Amount	Accidental Death Benefit	Year Issued
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			

Beneficiary Designation

9.	Name and Address	Relationship		%
Insured			Primary	
Insured			Contingent	
Spouse			Primary	
Spouse			Contingent	

If additional beneficiaries, use a separate sheet of paper. Signed and dated by the Insured.

MEDICAL QUESTIONS - PART 4

	PROPOSED INSURED		SPOUSE		CHILDREN TERM RIDER	
	Yes	No	Yes	No	Yes	No
10. IS ANY PERSON PROPOSED FOR INSURANCE currently in the hospital or receiving disability payments; or, in the past 5 years has any proposed insured been treated by a licensed member of the medical profession for a heart attack, internal cancer, melanoma, disease or disorder of the lungs, hepatitis, tested positive for exposure to HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
11. HAS ANY PERSON proposed for insurance in Part 1 and Part 2:						
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or considering such flying in the next two (2) years? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected (in the next two (2) years) activity in racing, skin or sky diving, bungee jumping, base jumping, parasailing, rock climbing, hang gliding or ultra-light flying? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified?	☐	☐	☐	☐	☐	☐
12. IN THE LAST 10 YEARS, HAS ANY PERSON proposed for insurance in Part 1 and Part 2 ever been treated by a licensed member of the medical profession for:						
(a) Heart attack, chest pain, heart murmur, high blood pressure or any other disease of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, or any other disease of the stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any other disease of the chest or lungs?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes; albumin, pus, blood or sugar in urine; venereal disease or any other disease of the kidneys, bladder, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Tested positive for exposure to HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
(h) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(i) Cancer, tumor or any other illness or injury not mentioned above?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
13. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1 and Part 2:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Had an immediate family member (Father, Mother, Brothers or Sisters) with a history of diabetes, mental, nervous, heart or circulatory disorder, tuberculosis, cancer, high blood pressure, kidney disease or suicide? In Details section below, include condition, relationship, age(s) if living, age(s) at death and cause of death.	☐	☐	☐	☐	☐	☐
14. IS ANY PERSON proposed for insurance in Part 1 and Part 2 now under observation or treatment or been advised to have any tests, hospitalization or surgery?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
15. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active: list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the space provided below for "Details".)*	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

DETAILS OF questions 10 - 15 answered "yes": Include question #, names and addresses of physicians and individuals to who history pertains.

If additional details, use a separate sheet of paper. Signed and dated by the Insured.

AGREEMENT Terms used In this Agreement:
"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:
(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.
(c) Unless the policy becomes effective as specified in the Temporary Insurance Agreement attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.
(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.
(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.
(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

Disclosures

Alabama, Arkansas, Louisiana, Mississippi, North Carolina, South Carolina: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial or insurance benefits.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best way to reach you?

Home/Office Phone:
Cell Phone:
Email address:

I represent that copies of all sales material have been left with the Proposed Insured.

Writing Agent

_____
Print Name State License No. (Req. in FL)

X _____
Signature LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

AGENT'S STATEMENT: Was the Temporary Life Insurance Agreement left with the owner? ☐ Yes ☐ No

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning any health condition listed on Part 4 of this application for any Proposed Insured.

Physician Information

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION I hereby authorize the above person(s) or entity(s) listed in above and the Medical Information Bureau and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama**, or to **[Lab One/Exam One]** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the person(s) named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes, pharmacy records or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization, I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends (twenty-four (24) months from the date shown below in Kentucky, thirty (30) months from the date shown below in Georgia and North Carolina), if not revoked before such date. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

BY THE SIGNATURE(s) below I (we) do attest that the statements and answers in all parts of this application are complete and true and will be the basis for any insurance issued.

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than Proposed Insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than Spouse

HOME OFFICE ENDORSEMENTS:

Temporary Life Insurance Agreement and Receipt

A copy of this Agreement is to be left with the owner if all questions are answered 'No' and pre-condition 2 is met. Second copy is sent with the Application.

Do not leave a copy of this Agreement or accept a payment if a question has a 'Yes" answer.

Instead, check "No" on the next page, page 8, and obtain the owner's initials under the acknowledgement section.

Definitions

For purposes of this Temporary Life Insurance Agreement ("Agreement"): "Application" means the Application for Individual Life Insurance from which this Agreement is to be and was physically detached and provided to the owner. "Agent" means the licensed individual who signed this Application as the Agent. "Proposed insured" means the person identified as the proposed life insured, and the person identified as the Spouse life insured, if any, in the Application. "Owner" is identified in the 'Information about the Owner' section of the Application.

Pre-Conditions to Temporary Coverage

Subject to the terms of this Agreement, Life of Alabama agrees to provide the temporary coverage set out in this Agreement if each of the following pre-conditions are met:

1. All questions in this Agreement are answered 'No' and the 'No' answers shown to the questions in this Agreement are truthful.
2. No later than the date of signing this Application, an amount equal to at least a monthly premium for the insurance applied for in the Application was given to the Agent or arrangements have been made for the insurance premium to be payroll deducted through the proposed insured's employer.

If either of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions

	Proposed Insured	Spouse
1. Within the past 12 months, has there been either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart-related illness, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 90 days, been admitted for more than 2 consecutive days to a hospital (other than for childbirth)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 90 days, has a licensed medical professional recommended a medical test, investigation or surgery, or combination thereof, which was refused to be undertaken or has not yet been undertaken?	☐ Yes ☐ No	☐ Yes ☐ No

Amount given to Agent is $_____ ☐ No amount given to Agent.

Amount of Temporary Coverage

Subject to the terms of this Agreement, if all of the above pre-conditions are met and a proposed insured dies while this Agreement is in effect, Life of Alabama shall pay under this and all other Life of Alabama temporary life insurance agreement(s), to the beneficiary(ies), as shown in the Application, for that proposed insured, the lesser of:

1. The amount of insurance applied for in the Application on the life of that deceased proposed insured, including the amount payable for the death of that proposed insured under a rider applied for; or
2. $100,000.

Termination of Temporary Coverage

Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further in force or effect, on the earliest of the following:

1. Sixty (60) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this sixty (60) day period.
2. The date an approved Life of Alabama policy on the life of a proposed insured takes effect as described in that policy, if a policy is issued in response to the Application.
3. The date Life of Alabama offers, as shown in Life of Alabama's records, the owner a Life of Alabama policy in response to, but not as applied for in, the Application.
4. The date a written or oral request to withdraw the Application is made by or on behalf of a proposed insured or the owner.
5. The date a written or oral request to terminate this Agreement is made by or on behalf of a proposed insured or the owner.
6. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to a proposed insured or the owner, terminating this Agreement.
7. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to the proposed insured or the owner, declining the Application.

Special Limitations

1. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Life of Alabama's liability to a refund of payment(s) made to Life of Alabama.
2. This Agreement shall be void if a check or draft given to the Agent is not honored when presented for payment.
3. If a proposed insured dies by suicide, whether sane or insane, Life of Alabama's liability under this Agreement is limited to a refund of the payment(s) made to Life of Alabama.
4. No temporary coverage will be provided under this Agreement to a proposed insured whose age is 66 or older on the date the Application is signed by the owner.

Payment to Life of Alabama

A check given to the Agent must be made payable to Life of Alabama. Do not make check payable to the Agent or leave the payee blank.

Entire Agreement

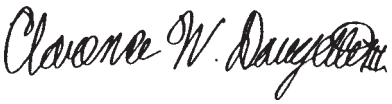
This Agreement contains the entire terms regarding temporary coverage. No one, including the Agent signing in the signature section of the Application, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement.

Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

I, a proposed insured and/or the owner, by signing in the signature section of this Application, acknowledge and agree that I have reviewed, understand, and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



Clarence W. Daugette, III
President

Temporary Life Insurance Agreement Acknowledgement

Was this Temporary Life Insurance Agreement left with the owner? ☐Yes ☐No
If No, owner acknowledges that there is no temporary life insurance coverage in effect _____
(owner's initials)

X _____
Agent Signature LICOA Agent's No.

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than spouse

Temporary Life Insurance Agreement and Receipt

A copy of this Agreement is to be left with the owner if all questions are answered 'No' and pre-condition 2 is met. Second copy is sent with the Application.

Do not leave a copy of this Agreement or accept a payment if a question has a 'Yes" answer.

Instead, check "No" on the next page, page 8, and obtain the owner's initials under the acknowledgement section.

Definitions

For purposes of this Temporary Life Insurance Agreement ("Agreement"): "Application" means the Application for Individual Life Insurance from which this Agreement is to be and was physically detached and provided to the owner. "Agent" means the licensed individual who signed this Application as the Agent. "Proposed insured" means the person identified as the proposed life insured, and the person identified as the Spouse life insured, if any, in the Application. "Owner" is identified in the 'Information about the Owner' section of the Application.

Pre-Conditions to Temporary Coverage

Subject to the terms of this Agreement, Life of Alabama agrees to provide the temporary coverage set out in this Agreement if each of the following pre-conditions are met:

1. All questions in this Agreement are answered 'No' and the 'No' answers shown to the questions in this Agreement are truthful.
2. No later than the date of signing this Application, an amount equal to at least a monthly premium for the insurance applied for in the Application was given to the Agent or arrangements have been made for the insurance premium to be payroll deducted through the proposed insured's employer.

If either of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions

	Proposed Insured	Spouse
1. Within the past 12 months, has there been either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart-related illness, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 90 days, been admitted for more than 2 consecutive days to a hospital (other than for childbirth)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 90 days, has a licensed medical professional recommended a medical test, investigation or surgery, or combination thereof, which was refused to be undertaken or has not yet been undertaken?	☐ Yes ☐ No	☐ Yes ☐ No

Amount given to Agent is $_____ ☐ No amount given to Agent.

Amount of Temporary Coverage

Subject to the terms of this Agreement, if all of the above pre-conditions are met and a proposed insured dies while this Agreement is in effect, Life of Alabama shall pay under this and all other Life of Alabama temporary life insurance agreement(s), to the beneficiary(ies), as shown in the Application, for that proposed insured, the lesser of:

1. The amount of insurance applied for in the Application on the life of that deceased proposed insured, including the amount payable for the death of that proposed insured under a rider applied for; or
2. $100,000.

Termination of Temporary Coverage

Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further in force or effect, on the earliest of the following:

1. Sixty (60) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this sixty (60) day period.
2. The date an approved Life of Alabama policy on the life of a proposed insured takes effect as described in that policy, if a policy is issued in response to the Application.
3. The date Life of Alabama offers, as shown in Life of Alabama's records, the owner a Life of Alabama policy in response to, but not as applied for in, the Application.
4. The date a written or oral request to withdraw the Application is made by or on behalf of a proposed insured or the owner.
5. The date a written or oral request to terminate this Agreement is made by or on behalf of a proposed insured or the owner.
6. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to a proposed insured or the owner, terminating this Agreement.
7. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to the proposed insured or the owner, declining the Application.

Special Limitations

1. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Life of Alabama's liability to a refund of payment(s) made to Life of Alabama.
2. This Agreement shall be void if a check or draft given to the Agent is not honored when presented for payment.
3. If a proposed insured dies by suicide, whether sane or insane, Life of Alabama's liability under this Agreement is limited to a refund of the payment(s) made to Life of Alabama.
4. No temporary coverage will be provided under this Agreement to a proposed insured whose age is 66 or older on the date the Application is signed by the owner.

Payment to Life of Alabama

A check given to the Agent must be made payable to Life of Alabama. Do not make check payable to the Agent or leave the payee blank.

Entire Agreement

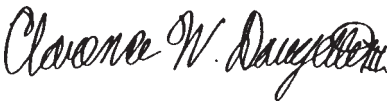
This Agreement contains the entire terms regarding temporary coverage. No one, including the Agent signing in the signature section of the Application, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement.

Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

I, a proposed insured and/or the owner, by signing in the signature section of this Application, acknowledge and agree that I have reviewed, understand, and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



Clarence W. Daugette, III
President

Temporary Life Insurance Agreement Acknowledgement

Was this Temporary Life Insurance Agreement left with the owner? ☐Yes ☐No
If No, owner acknowledges that there is no temporary life insurance coverage in effect _____
(owner's initials)

X _____
Agent Signature LICOA Agent's No.

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Insured

X _____
Signature of Owner or Applicant if other than proposed insured

X _____
Signature of Spouse

X _____
Signature of Owner or Applicant if other than spouse

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

A copy of this Agreement is to be left with the applicant. Second copy is sent with the Application.

If the applicant has an existing policy or contract, the agent or broker who initiated the application must present and read to the applicant, no later than at the time of taking the application, a completed and signed copy of the "Notice Regarding Replacement". The following procedures apply even if there is no intention to replace an existing policy or contract:

The notice must be signed by both the applicant and agent attesting that the notice has been read aloud by the agent or that the applicant did not wish the notice to be read aloud and that a copy of the notice was left with the applicant.

This notice must be completed by listing all policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number, if available, or alternative identification such as an application or receipt number. Also, the list shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for a new policy.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

_____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X _____
Agent Signature LICOA Agent's No.

X_____
Signature of Owner or Applicant if other than spouse

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

A copy of this Agreement is to be left with the applicant. Second copy is sent with the Application.

If the applicant has an existing policy or contract, the agent or broker who initiated the application must present and read to the applicant, no later than at the time of taking the application, a completed and signed copy of the "Notice Regarding Replacement". The following procedures apply even if there is no intention to replace an existing policy or contract:

The notice must be signed by both the applicant and agent attesting that the notice has been read aloud by the agent or that the applicant did not wish the notice to be read aloud and that a copy of the notice was left with the applicant.

This notice must be completed by listing all policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number, if available, or alternative identification such as an application or receipt number. Also, the list shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for a new policy.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

_____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Insured

X _____
Signature of Owner or Applicant if other than proposed insured

X _____
Signature of Spouse

X _____
Signature of Owner or Applicant if other than spouse

X _____
Agent Signature LICOA Agent's No.

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

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You may need a medical exam for a new policy.
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How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

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Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of financial institution_____ City_____ State_____

I would like the payment withdrawn on the_____ (select the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no._____

Signature as it appears on bank records (do not print) X_____

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of financial institution_____ City_____ State_____

I would like the payment withdrawn on the_____ (select the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no._____

Signature as it appears on bank records (do not print) X_____

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (***PLEASE PRINT OR TYPE***)

EFFECTIVE DATE	NAME OF EMPLOYEE	SOCIAL SECURITY NO.
DEPT. NO.	NAME OF EMPLOYER	MONTHLY PREMIUM
EMP. NO.	INDICATE TYPE OF COVERAGE	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

_____ X _____

DATE SIGNATURE OF EMPLOYEE

Cut along dotted line.

This Notice is to be detached, read, and retained by the Proposed Insured

FAIR CREDIT REPORT ACT NOTICE

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided. **You or any person authorized to act on your behalf are entitled to receive a copy of this Authorization Form.**

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

MEDICAL INFORMATION BUREAU, INC. (MIB), NOTICE Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com. The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

SERFF Tracking Number:	*WAKE-126945784*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*47525*
Company Tracking Number:	*KEGLOAAPPAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Life Application*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOAAPPAR*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
MP LIFE 1010 Readability Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Attachment:
MP LIFE 1010.pdf

Item Status: **Status Date:**

Satisfied - Item: Authorization Letter
Comments:
Attachment:
Authorization Letter.pdf

Item Status: **Status Date:**

Satisfied - Item: Cover Letter
Comments:
Attachment:
AR Cover Letter.pdf

READABILITY COMPLIANCE CERTIFICATION

Name and Address of the Insurer:

Life Insurance Company of Alabama
P.O. Box 349
302 Broad Street
Gadsden, AL 35902

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Type and/or Title of Form(s)	Form Number(s)	Flesch Score
Application for Life Insurance	MP LIFE 1010	45.8

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.

J. Steven Keck
Name:

Chief Operating Officer
Title:

December 13, 2010
Date:

APPLICATION FOR LIFE INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.

Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

Proposed Insured

NAME (Last, Suffix, First, M.I.)_____

BIRTHDATE ___/___/_____ STATE OF BIRTH ____ SSN# ___-___-_____

HEIGHT ___' ___" WEIGHT ____ MALE ☐ FEMALE ☐ _____ ____ ISSUE STATE
Driver License #

ADDRESS_____

CITY_____ STATE ____ ZIP _____

EMAIL _____ PHONE ___-___-_____

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ___/___/_____

OCCUPATION_____
Describe and give exact duties

1. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **1a. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE ☐ E-Z Underwriting (Subject to Question 10 and Company Participation requirements)	$ ___,___	$ ___,___.___
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$ ___,___	$ ___,___.___
☐ ACCIDENTAL DEATH BENEFIT	$ ___,___	$ ___,___.___
☐ CHILDRENS TERM ____ UNITS 15 units maximum per family		$ ___,___.___
☐ WAIVER OF PREMIUM		$ ___,___.___
☐ AUTOMATIC PREMIUM LOAN Yes ☐ No ☐ Whole Life Only	TOTAL MODE PREMIUM	$ ___,___.___

Ownership

2. OWNER if other than PROPOSED INSURED

Name _____ *Relationship to Insured* _____

Street _____ Owner's SSN# or TAX ID# ___-___-_____

City _____ *State*____ *ZIP*_____

Proposed Insured becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

3. NAME	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

APPLICATION FOR LIFE INSURANCE - PART 2

Spouse

NAME (Last, Suffix, First, M.I.)_____

BIRTHDATE ☐☐/☐☐/☐☐☐☐ STATE OF BIRTH ☐☐ SSN# ☐☐☐-☐☐-☐☐☐☐

HEIGHT ☐'☐☐" WEIGHT ☐☐☐ MALE ☐ FEMALE ☐ _____ ☐☐ ISSUE STATE
Driver License #

ADDRESS_____
☐ Same address as Proposed Insured

CITY_____ STATE ☐☐ ZIP ☐☐☐☐☐

EMAIL _____ PHONE ☐☐☐-☐☐☐-☐☐☐☐

SPOUSE'S EMPLOYER _____ EMPLOYMENT DATE ☐☐/☐☐/☐☐☐☐

OCCUPATION_____
Describe and give exact duties

4. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **4a. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ ACCIDENTAL DEATH BENEFIT	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ CHILDRENS TERM ☐☐ UNITS 15 units maximum per family		$ ☐,☐☐☐.☐☐
☐ WAIVER OF PREMIUM		$ ☐,☐☐☐.☐☐
☐ AUTOMATIC PREMIUM LOAN Whole Life Only Yes ☐ No ☐	TOTAL MODE PREMIUM	$ ☐,☐☐☐.☐☐

Ownership

5. OWNER if other than SPOUSE

Name _____ *Relationship to Insured* _____

Street _____ Owner's SSN# or TAX ID# ☐☐☐-☐☐-☐☐☐☐

City _____ *State*____ *ZIP*_____

Spouse becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

6. NAME	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

Payment Info. Insured

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Proposed Insured's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Payment Info. Spouse

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7a. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Spouse's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Existing Insurance

8. EXISTING or APPLIED FOR INSURANCE

Does any Proposed Insured have any existing life insurance or annuity contracts in force or applications pending? Yes ☐ No ☐

If YES, complete and submit attached replacement forms with this application and list all in force and pending life insurance coverage below.

Insured's Name	Company	Owner	Replacement	Life Amount	Accidental Death Benefit	Year Issued
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			

Beneficiary Designation

9.	Name and Address	Relationship		%
Insured			Primary	
Insured			Contingent	
Spouse			Primary	
Spouse			Contingent	

If additional beneficiaries, use a separate sheet of paper. Signed and dated by the Insured.

MEDICAL QUESTIONS - PART 4

	PROPOSED INSURED		SPOUSE		CHILDREN TERM RIDER	
	Yes	No	Yes	No	Yes	No
10. IS ANY PERSON PROPOSED FOR INSURANCE currently in the hospital or receiving disability payments; or, in the past 5 years has any proposed insured been treated by a licensed member of the medical profession for a heart attack, internal cancer, melanoma, disease or disorder of the lungs, hepatitis, tested positive for exposure to HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
11. HAS ANY PERSON proposed for insurance in Part 1 and Part 2:						
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or considering such flying in the next two (2) years? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected (in the next two (2) years) activity in racing, skin or sky diving, bungee jumping, base jumping, parasailing, rock climbing, hang gliding or ultra-light flying? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified?	☐	☐	☐	☐	☐	☐
12. IN THE LAST 10 YEARS, HAS ANY PERSON proposed for insurance in Part 1 and Part 2 ever been treated by a licensed member of the medical profession for:						
(a) Heart attack, chest pain, heart murmur, high blood pressure or any other disease of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, or any other disease of the stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any other disease of the chest or lungs?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes; albumin, pus, blood or sugar in urine; venereal disease or any other disease of the kidneys, bladder, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Tested positive for exposure to HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
(h) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(i) Cancer, tumor or any other illness or injury not mentioned above?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
13. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1 and Part 2:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Had an immediate family member (Father, Mother, Brothers or Sisters) with a history of diabetes, mental, nervous, heart or circulatory disorder, tuberculosis, cancer, high blood pressure, kidney disease or suicide? In Details section below, include condition, relationship, age(s) if living, age(s) at death and cause of death.	☐	☐	☐	☐	☐	☐
14. IS ANY PERSON proposed for insurance in Part 1 and Part 2 now under observation or treatment or been advised to have any tests, hospitalization or surgery?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
15. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active: list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the space provided below for "Details".)*	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

DETAILS OF questions 10 - 15 answered "yes": Include question #, names and addresses of physicians and individuals to who history pertains.

If additional details, use a separate sheet of paper. Signed and dated by the Insured.

AGREEMENT Terms used In this Agreement:
"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:
(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.
(c) Unless the policy becomes effective as specified in the Temporary Insurance Agreement attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.
(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.
(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.
(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

Disclosures

Alabama, Arkansas, Louisiana, Mississippi, North Carolina, South Carolina: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial or insurance benefits.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best way to reach you?

Home/Office Phone:
Cell Phone:
Email address:

I represent that copies of all sales material have been left with the Proposed Insured.

Writing Agent

_____
Print Name State License No. (Req. in FL)

X _____
Signature LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

AGENT'S STATEMENT: Was the Temporary Life Insurance Agreement left with the owner? ☐ Yes ☐ No

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning any health condition listed on Part 4 of this application for any Proposed Insured.

Physician Information

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION I hereby authorize the above person(s) or entity(s) listed in above and the Medical Information Bureau and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama**, or to **[Lab One/Exam One]** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the person(s) named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes, pharmacy records or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization, I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends (twenty-four (24) months from the date shown below in Kentucky, thirty (30) months from the date shown below in Georgia and North Carolina), if not revoked before such date. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

BY THE SIGNATURE(s) below I (we) do attest that the statements and answers in all parts of this application are complete and true and will be the basis for any insurance issued.

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than Proposed Insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than Spouse

HOME OFFICE ENDORSEMENTS:

Temporary Life Insurance Agreement and Receipt

A copy of this Agreement is to be left with the owner if all questions are answered 'No' and pre-condition 2 is met. Second copy is sent with the Application.

Do not leave a copy of this Agreement or accept a payment if a question has a 'Yes" answer.

Instead, check "No" on the next page, page 8, and obtain the owner's initials under the acknowledgement section.

Definitions

For purposes of this Temporary Life Insurance Agreement ("Agreement"): "Application" means the Application for Individual Life Insurance from which this Agreement is to be and was physically detached and provided to the owner. "Agent" means the licensed individual who signed this Application as the Agent. "Proposed insured" means the person identified as the proposed life insured, and the person identified as the Spouse life insured, if any, in the Application. "Owner" is identified in the 'Information about the Owner' section of the Application.

Pre-Conditions to Temporary Coverage

Subject to the terms of this Agreement, Life of Alabama agrees to provide the temporary coverage set out in this Agreement if each of the following pre-conditions are met:

1. All questions in this Agreement are answered 'No' and the 'No' answers shown to the questions in this Agreement are truthful.
2. No later than the date of signing this Application, an amount equal to at least a monthly premium for the insurance applied for in the Application was given to the Agent or arrangements have been made for the insurance premium to be payroll deducted through the proposed insured's employer.

If either of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions

	Proposed Insured	Spouse
1. Within the past 12 months, has there been either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart-related illness, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 90 days, been admitted for more than 2 consecutive days to a hospital (other than for childbirth)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 90 days, has a licensed medical professional recommended a medical test, investigation or surgery, or combination thereof, which was refused to be undertaken or has not yet been undertaken?	☐ Yes ☐ No	☐ Yes ☐ No

Amount given to Agent is $_____ ☐ No amount given to Agent.

Amount of Temporary Coverage

Subject to the terms of this Agreement, if all of the above pre-conditions are met and a proposed insured dies while this Agreement is in effect, Life of Alabama shall pay under this and all other Life of Alabama temporary life insurance agreement(s), to the beneficiary(ies), as shown in the Application, for that proposed insured, the lesser of:

1. The amount of insurance applied for in the Application on the life of that deceased proposed insured, including the amount payable for the death of that proposed insured under a rider applied for; or
2. $100,000.

Termination of Temporary Coverage

Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further in force or effect, on the earliest of the following:

1. Sixty (60) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this sixty (60) day period.
2. The date an approved Life of Alabama policy on the life of a proposed insured takes effect as described in that policy, if a policy is issued in response to the Application.
3. The date Life of Alabama offers, as shown in Life of Alabama's records, the owner a Life of Alabama policy in response to, but not as applied for in, the Application.
4. The date a written or oral request to withdraw the Application is made by or on behalf of a proposed insured or the owner.
5. The date a written or oral request to terminate this Agreement is made by or on behalf of a proposed insured or the owner.
6. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to a proposed insured or the owner, terminating this Agreement.
7. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to the proposed insured or the owner, declining the Application.

Special Limitations

1. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Life of Alabama's liability to a refund of payment(s) made to Life of Alabama.
2. This Agreement shall be void if a check or draft given to the Agent is not honored when presented for payment.
3. If a proposed insured dies by suicide, whether sane or insane, Life of Alabama's liability under this Agreement is limited to a refund of the payment(s) made to Life of Alabama.
4. No temporary coverage will be provided under this Agreement to a proposed insured whose age is 66 or older on the date the Application is signed by the owner.

Payment to Life of Alabama

A check given to the Agent must be made payable to Life of Alabama. Do not make check payable to the Agent or leave the payee blank.

Entire Agreement

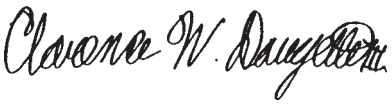
This Agreement contains the entire terms regarding temporary coverage. No one, including the Agent signing in the signature section of the Application, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement.

Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

I, a proposed insured and/or the owner, by signing in the signature section of this Application, acknowledge and agree that I have reviewed, understand, and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



Clarence W. Daugette, III
President

Temporary Life Insurance Agreement Acknowledgement

Was this Temporary Life Insurance Agreement left with the owner? ☐Yes ☐No
If No, owner acknowledges that there is no temporary life insurance coverage in effect _____
(owner's initials)

X _____
Agent Signature LICOA Agent's No.

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than spouse

Temporary Life Insurance Agreement and Receipt

A copy of this Agreement is to be left with the owner if all questions are answered 'No' and pre-condition 2 is met. Second copy is sent with the Application.

Do not leave a copy of this Agreement or accept a payment if a question has a 'Yes" answer.

Instead, check "No" on the next page, page 8, and obtain the owner's initials under the acknowledgement section.

Definitions

For purposes of this Temporary Life Insurance Agreement ("Agreement"): "Application" means the Application for Individual Life Insurance from which this Agreement is to be and was physically detached and provided to the owner. "Agent" means the licensed individual who signed this Application as the Agent. "Proposed insured" means the person identified as the proposed life insured, and the person identified as the Spouse life insured, if any, in the Application. "Owner" is identified in the 'Information about the Owner' section of the Application.

Pre-Conditions to Temporary Coverage

Subject to the terms of this Agreement, Life of Alabama agrees to provide the temporary coverage set out in this Agreement if each of the following pre-conditions are met:

1. All questions in this Agreement are answered 'No' and the 'No' answers shown to the questions in this Agreement are truthful.
2. No later than the date of signing this Application, an amount equal to at least a monthly premium for the insurance applied for in the Application was given to the Agent or arrangements have been made for the insurance premium to be payroll deducted through the proposed insured's employer.

If either of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions

	Proposed Insured	Spouse
1. Within the past 12 months, has there been either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart-related illness, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 90 days, been admitted for more than 2 consecutive days to a hospital (other than for childbirth)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 90 days, has a licensed medical professional recommended a medical test, investigation or surgery, or combination thereof, which was refused to be undertaken or has not yet been undertaken?	☐ Yes ☐ No	☐ Yes ☐ No

Amount given to Agent is $_____ ☐ No amount given to Agent.

Amount of Temporary Coverage

Subject to the terms of this Agreement, if all of the above pre-conditions are met and a proposed insured dies while this Agreement is in effect, Life of Alabama shall pay under this and all other Life of Alabama temporary life insurance agreement(s), to the beneficiary(ies), as shown in the Application, for that proposed insured, the lesser of:

1. The amount of insurance applied for in the Application on the life of that deceased proposed insured, including the amount payable for the death of that proposed insured under a rider applied for; or
2. $100,000.

Termination of Temporary Coverage

Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further in force or effect, on the earliest of the following:

1. Sixty (60) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this sixty (60) day period.
2. The date an approved Life of Alabama policy on the life of a proposed insured takes effect as described in that policy, if a policy is issued in response to the Application.
3. The date Life of Alabama offers, as shown in Life of Alabama's records, the owner a Life of Alabama policy in response to, but not as applied for in, the Application.
4. The date a written or oral request to withdraw the Application is made by or on behalf of a proposed insured or the owner.
5. The date a written or oral request to terminate this Agreement is made by or on behalf of a proposed insured or the owner.
6. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to a proposed insured or the owner, terminating this Agreement.
7. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to the proposed insured or the owner, declining the Application.

Special Limitations

1. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Life of Alabama's liability to a refund of payment(s) made to Life of Alabama.
2. This Agreement shall be void if a check or draft given to the Agent is not honored when presented for payment.
3. If a proposed insured dies by suicide, whether sane or insane, Life of Alabama's liability under this Agreement is limited to a refund of the payment(s) made to Life of Alabama.
4. No temporary coverage will be provided under this Agreement to a proposed insured whose age is 66 or older on the date the Application is signed by the owner.

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A check given to the Agent must be made payable to Life of Alabama. Do not make check payable to the Agent or leave the payee blank.

Entire Agreement

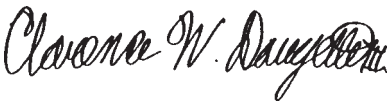
This Agreement contains the entire terms regarding temporary coverage. No one, including the Agent signing in the signature section of the Application, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement.

Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

I, a proposed insured and/or the owner, by signing in the signature section of this Application, acknowledge and agree that I have reviewed, understand, and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



Clarence W. Daugette, III
President

Temporary Life Insurance Agreement Acknowledgement

Was this Temporary Life Insurance Agreement left with the owner? ☐Yes ☐No
If No, owner acknowledges that there is no temporary life insurance coverage in effect _____
(owner's initials)

X _____
Agent Signature LICOA Agent's No.

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Insured

X _____
Signature of Owner or Applicant if other than proposed insured

X _____
Signature of Spouse

X _____
Signature of Owner or Applicant if other than spouse

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

A copy of this Agreement is to be left with the applicant. Second copy is sent with the Application.

If the applicant has an existing policy or contract, the agent or broker who initiated the application must present and read to the applicant, no later than at the time of taking the application, a completed and signed copy of the "Notice Regarding Replacement". The following procedures apply even if there is no intention to replace an existing policy or contract:

The notice must be signed by both the applicant and agent attesting that the notice has been read aloud by the agent or that the applicant did not wish the notice to be read aloud and that a copy of the notice was left with the applicant.

This notice must be completed by listing all policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number, if available, or alternative identification such as an application or receipt number. Also, the list shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for a new policy.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

_____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X _____
Agent Signature LICOA Agent's No.

X_____
Signature of Owner or Applicant if other than spouse

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

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I certify that the responses herein are, to the best of my knowledge, accurate:

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Insured

X _____
Signature of Owner or Applicant if other than proposed insured

X _____
Signature of Spouse

X _____
Signature of Owner or Applicant if other than spouse

X _____
Agent Signature LICOA Agent's No.

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What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of financial institution_____ City_____ State_____

I would like the payment withdrawn on the_____ (select the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no._____

Signature as it appears on bank records (do not print) X_____

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of financial institution_____ City_____ State_____

I would like the payment withdrawn on the_____ (select the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no._____

Signature as it appears on bank records (do not print) X_____

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (***PLEASE PRINT OR TYPE***)

EFFECTIVE DATE	NAME OF EMPLOYEE	SOCIAL SECURITY NO.
DEPT. NO.	NAME OF EMPLOYER	MONTHLY PREMIUM
EMP. NO.	INDICATE TYPE OF COVERAGE	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

_____ X _____

DATE SIGNATURE OF EMPLOYEE

Cut along dotted line.

This Notice is to be detached, read, and retained by the Proposed Insured

FAIR CREDIT REPORT ACT NOTICE

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided. **You or any person authorized to act on your behalf are entitled to receive a copy of this Authorization Form.**

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

MEDICAL INFORMATION BUREAU, INC. (MIB), NOTICE Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com. The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

LIFE INSURANCE COMPANY of Alabama

HOME OFFICE
P. O. BOX 349
GADSDEN, ALABAMA 35902
Phone: (256) 543-2022

June 29, 2010

Wakely Actuarial Services, Inc.
34125 US Highway 19 North, Suite 310
Palm Harbor, Florida 34684

To Whom It May Concern:

The firm of Wakely Actuarial Services, Inc. is hereby authorized to submit forms, rate filings or other filings requiring actuarial certification for approval to the Department of Insurance on behalf of Life Insurance Company of Alabama. Revisions to the filings, as may be necessary to gain approval, are included in this authorization.

Sincerely,

Clarence W. Daugette, III
President

CWDIII/js

December 13, 2010

Arkansas Department of Insurance

RE: Life Insurance Company of Alabama
NAIC NUMBER: 65412
FEIN NUMBER: 63-0321291

SUBMISSION – REPLACEMENT APPLICATION FORM

Application for Life Insurance MP LIFE 1010

Dear Sirs:

Wakely Actuarial Services, Inc. is filing the above referenced form, for your approval, on behalf of the Life Insurance Company of Alabama. A letter of authorization is enclosed.

This form will replace application form MP LIFE 7-10 previously approved by your Department on 08/11/2010. Duplicate copies of this form are enclosed for your review, together with the Flesch score certifications, and any required transmittals and filing fees.

Application Form MP LIFE 1010 will be used only in conjunction with the Whole Life Insurance Policy (Form 2004 WL142) and Term Life Insurance Policy (Form LT300). Both policy forms have previously been approved by your Department.

Wakely Actuarial Services, Inc. appreciates the Department's time and consideration in the review of this filing for the Life Insurance Company of Alabama. Please let us know if you should have any questions or comments.

Sincerely,

Katlyn Gorman
Administrative Assistant

888-590-5504, Extension 2100
Email: Katlyn.gorman@wakelyactuarial.com

Enclosures